PHILADELPHIA NEUROLOGICAL SOCIETY.

April 26th, 1897. President, Dr. Charles W. Burr, in the chair.

Dr. Judson Daland reported

A CASE OF DYSPHAGIA AND DYSPHASIA RESULTING FROM A LESION IN THE INTERNAL CAPSULE. (See this journal, page 614.)

Dr. Joseph Leidy, Jr.—This patient had been under my care for two or three years previous to his last attack. The symptoms referable to speech and to motor palsy entirely disappeared. His first attack occurred some eighteen months previously, and after an illness of a week or ten days, the motor symptoms, as well as the dysphagia and dysphasia, entirely disappeared. They were so evanescent that it was a question whether or not there was an organic lesion. He had recurring attacks after this at intervals of four or five months, and after each one the symptoms disappeared. Dr. Grayson examined the throat and found paresis of the right vocal cord. The speech was somewhat indistinct, but the tongue when protruded showed no deviation.

Dr. Wm. G. Spiller.—This is the second case of capsular monoplegia which has come under my observation. The first was a case presented by Ballet in his lectures in Paris, in 1895, but I am not aware that it has been published. The man, I believe, had paralysis of one limb, and at the autopsy a lesion was found in the internal capsule. I am under the impression that Dejerine has reported a case of capsular monoplegia, and that one has been recorded by one of the English writers, but I am unable to give the references to these. An important case of facial monoplegia of capsular origin was published last year by Etienne.

The disappearance of the symptoms in Dr. Daland's patient is hardly surprising, even if they were entirely due to a capsular lesion. Muscles which act together probably have a bilateral representation in the cortex, and certain of these muscles probably cannot be permanently paralyzed by an unilateral cortical or capsular lesion. Indeed, when the lesion occurs early in life, the restoration of function may be considerable, even when the pyramidal tract is destroyed, as in two cases with autopsy, which have recently come under my observation. In a paper by Zacher a case is reported in which the hemiplegia in an adult only lasted a short time, with the exception of the persistence of a certain weakness and uncertainty of movement. At the autopsy, however, the corresponding pyramidal tract was found to be greatly degenerated.

It seems to me that the aneurysm of the right vertebral artery in Dr. Daland's case must be considered in explaining the symptoms. The paresis of the right vocal cord might have been due to pressure on the right vagus, and could not be explained by a lesion of the right internal capsule.

Dr. Judson Daland.—The case is interesting from the fact that we have here evidences of extreme arteriocapillary fibrosis with extreme cardiorenal changes. I am particularly interested in the condition of the right vertebral and basilar arteries. Careful examination shows that they are markedly dilated. It seems to me the dilated artery in this situation was abundantly able to exert compression on the pneumogastric, the hypoglossal, and probably the glossopharyngeal nerves. It may be that pressure on these nerves may explain a certain portion of the complex clinical picture presented by this case. I am also interested in the occurrence of Cheyne-Stokes breathing, a symptom which, when it occurs, is usually a speedy precursor of death. It seems to me that probably the chronic Cheyne-Stokes breathing was due in part to feeble circulation, in part to intermittent uremia, and in part to pressure exerted by the aneurysm of the right vertebral and basilar arteries.

Dr. A. Ferree Witmer presented a case of

ACUTE CHOREA IN A WOMAN AGED THIRTY-EIGHT.

This patient was a native of Scotland; was married; of temperate habits, and of excellent family history.

In the autumn of 1893 she fell a distance of twenty feet, but, aside from the shock, received no apparent injury, as she returned to her housework two days after the fall. Six months later the twitching began. This was sudden in onset, more marked on the left side, and has persisted with occasional weekly remissions to the present day.

The patient was of good physique; the eye grounds were normal; the vegetative functions and the mentality were undisturbed, and the speech was slow and of lowered pitch. The face, neck, body and extremities were the seat of abrupt, irregular movements. The tongue shared in these movements and gave rise at times to a clacking sound as it darted to and from the teeth. The movements intermitted during brief volitional acts, but recurred later with increased violence. Rest lessened the intensity, but sleep did not restrain them. The gait was irregularly spasmodic; the knee-jerks were greatly exaggerated; and the elbow-jerks were present. The patient had been taking ascending doses of Fowler's solution for a long period without benefit.

In conclusion comparisons were made between this disorder and palmus, which in many features, the speaker thought, it resembled.

Dr. Wharton Sinkler.—This patient presents the usual picture of chronic, adult chorea, which may, or may not, be hereditary. Quite a number of patients in the nervous wards of the Philadelphia Hospital have presented very much the same features which we see in hereditary chorea, and yet there has been no history of similar trouble in their ancestors. The continuance of the movements during sleep is peculiar in this case, for in adult chorea, as well as in Sydenham's chorea, the movements do not continue during sleep.

Dr. Wharton Sinkler read a paper, entitled:

A CASE OF TROPHONEUROSIS OF THE HANDS (ACROTROPHONEUROSIS) WITH SPONTANEOUS AMPUTATION OF THE FINGERS.

(To appear in a later number of this journal.)

Dr. Milton B. Hartzel.—I have observed this case for a number of years. I have been much interested in it chiefly on account of its great obscurity. It is singular that in a large proportion of these cases, the injury which preceded the gangrene has been a burn, not always by fire, but sometimes by chemicals. Until recently most of the cases reported have been in women. Two have been reported in men; in one of these the man is said to have been hysterical. I must confess that the term "trophoneurosis" does not convey much that is explanatory to me. In this case the burn occurred on the left arm, which is now healed. Why the trophic lesions should have developed on the right side is a matter that I cannot explain. So far as I can see, her condition is not at all changed, except that there has been great improvement in the general health. The condition of the skin is about the same that it was five or six years ago.

Dr. J. H. W. Rhein presented

A CASE OF ATAXIC PARAPLEGIA, AND A CASE OF POISONING FROM BENZINE VAPOR.

Dr. Charles W. Burr.—It seems to me that the latter case is certainly largely, if not altogether, hysterical. Both history and symptoms point in that direction. The peculiar attacks which develop on fixation of an object certainly are not epileptic.

Dr. John K. Mitchell read a paper on

HEADACHE WITH VISUAL HALLUCINATION. (See this journal, page 620.)

Dr. Joseph Leidy, Jr.—Has the blood in this case been examined?

Dr. Wharton Sinkler.—Does this patient have epileptiform attacks not in connection with the headache, and are these attacks induced by overfatigue, nervous excitement or similar causes? The visual hallucination is quite different in this case from those which usually occur in connection with migraine. In this case the long continuance of the visual hullucination, its definite form, and the conversation which the patient had with the giant would seem more like a psychical disturbance than a subjective visual disorder in the higher nerve centres. I have seen two patients who had visual hallucinations preceding epileptic attacks. In one case they took the form of a beautiful landscape, lasting for a moment, before unconsciousness, and in the other that of a hideous head.

Dr. William G. Spiller.—Scotomata, consisting of zigzag or fortification lines, are well known in ophthalmic migraine, but such hallucinations as Dr. Mitchell describes are, as far as I know, exceedingly rare. Cases of ophthalmic migraine with temporary hemiplegia, hemianesthesia and aphasia have been carefully observed. There are certain features of Dr. Mitchell's case, which are suggestive of hysteria, and if this affection can be excluded the case is a most valuable connecting link between epilepsy and migraine. It is well known that many neurologists believe there is a connection between these two diseases, at least between epilepsy and the ophthalmic form of migraine.

Dr. J. K. Mitchell.—I thought I had stated in my paper that no trace of malaria had been found. As to the occurrence of the attack, that, too, I thought I had made sufficiently clear. It never occurred except when the patient had headache; nor did it seem to be brought on by fatigue, emotion nor other cause. If the case is one of hysteria, it certainly is a new variety of hysteria, and one which occurs only in summer time.

The point on which no one has commented is the one which seems to me the most interesting in the case—the apparent causal relation between the visual hullucination and the attack which followed.

Dr. A. A. Eshner read

A CONTRIBUTION TO THE STATISTICS OF THE MUSCULAR DYSTROPHIES.

He reported an analysis of twenty cases of progressive muscular dystrophy, collected from the records of the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases. These cases appear from the recorded notes to be of mixed type with a predominant tendency to pseudohypertrophy. Only four occurred in females, a proportion of 1 to 4. Gowers, in speaking of pseudohypertrophic paralysis, gives the proportion of the sexes as 1 to 4 to 7. In twenty-four cases of pseudohypertrophy, which came under his observation, he found the proportion 1 to 7 (three females, twenty-one males), and among two hundred and twenty cases, collected from various sources, the proportion was 1 to 6.3 (thirty females, a hundred and ninety males). In eighty-four cases Poole found eleven in females and seventy-three in males (1 to 6.6). Eichhorst quotes Seydel as having found among a hundred and twenty-five cases, twenty-two in girls and a hundred and three in boys (1 to 4.7).

So far as could be ascertained, the first symptoms in the cases here reported were noticed in none later than the thirteenth year; in two they were noticed at birth; in two during the first year; in two during the second year; in two during the third year; in two during the fourth year; in three during the sixth year; in one during the seventh year; in three during the eighth year; in two during the ninth year; and in one during the tenth year.

The ages of the patients at the time they came under observation were as follows: one was three years old; two, seven years; three, eight years; four, nine years; two, ten years; one, nineteen years; two, twenty-two years; one, twenty-four years.

In only two of the cases (brothers) was it definitely stated that similar disease existed in other members of the same family, although in one other case the statement, which could not be verified, was made that a great-grandfather and a grandfather had suffered from a similar disease. These findings are not in accord with the results of the analysis made by Gowers of two hundred and twenty cases, of which a hundred and two were isolated, and a hundred and eighteen occurred in thirty-nine families. Erb gives the proportion of hereditary and familial cases as 56 per cent. In six of Poole's cases other members of the family had suffered from a similar disease.

In ten cases one or more of the infectious diseases had preceded the onset of the dystrophic manifestations. In two the labor was said to have been difficult; in a third, instruments had been used in the delivery; in a fourth, the mother had suffered from dystocia in a previous labor, on account of the large size of the child; and in a fifth, it was stated that the mother had suffered considerably from anxiety during the pregnancy. In three cases there had been falls upon the back before the advent of the symptoms of the muscular trouble. The father of one patient had been alcoholic and his family tuberculous; the father of another had died in the sequence of an apoplectic attack. An uncle of another patient had been insane. The grandfather of one had been paralyzed. One sister of another patient had died of meningitis, and one of another during dentition.

In two of the cases contraction of the muscles of the upper part of the thigh (in the one instance of the external muscles, in the other of the extensors of the leg) was noted when the sole of the corresponding foot was gently irritated, notwithstanding the absence of the plantar reflex. The writer has since observed a similar phenomenon under other conditions also, when the plantar reflex was not interfered with.

In none of the cases reported in this study is any specific reference made to the race of the patients, and the writer thinks it is not unfair to assume that even those cases in which there was no definite knowledge upon this point, occurred in white persons, inasmuch as the matter of race has always received special consideration at the Infirmary, and the physicians under whose care they were have no recollection of ever having seen a case in a colored person. Nowhere in the literature has the writer seen any reference to the occurrence of the dystrophies in other than white persons, and his personal experience, together with information derived from a variety of sources, points to the rarity of these diseases in blacks. Numerous replies to letters addressed by him to neurologists and general practitioners in various parts of the country are in general quite confirmatory of the fact that the muscular dystrophies occur with the utmost rarity in colored persons, and especially in those of pure unmixed African parentage.

Dr. F. Savary Pearce reported

THREE CASES OF TRAUMATIC ANESTHESIA.

from the clinic of Dr. J. Madison Taylor, at the Howard Hospital. Two of these were the result of nerve section, and one of nerve contusion and compression. These cases showed entire loss of touch, pain and temperature senses in areas exactly defined by the distribution of the injured nerves. The speaker stated that in many instances where ill-defined areas of anesthesia exist after nerve trauma, all the fibres of the injured nerves are not divided, though in other cases complete severance is proven beyond doubt; and yet the loss of sensation or motion is not proportionate to the injury.

Case I. The patient, a colored laborer of thirty years, was referred from the surgical clinic of Dr. Edward Martin. Three weeks before coming to the hospital, he had thrust his right hand through a window pane and cut his wrist on the anterior side. A deep diagonal scar was found, two and a half inches long, just above the styloid process of the ulna, and extending over and through the median nerve. There had been, according to the statement of the patient, complete loss of sensation in the peripheral distribution of the median nerve since the second day of the injury. This loss of sensation was observed at the first visit of the patient to the clinic of Dr. Taylor. The thumb, index and middle fingers were edematous, and the index finger was ulcerated. The grasp of the hand was fairly good. Slight reaction of degeneration was found. Nerve suture was advised, and Dr. Martin united the divided ends of the nerve three weeks later. Restoration of function began at once, and the mobility of the hand was re covered *pari passu* with the sensation. The ulcer on the right index finger healed more slowly. The restoration of function was almost complete after seven months.

Case II. J. F., aged thirty, a laborer, fell from a scaffold five months previous to his visit to the hospital, and struck his right wrist on a piece of broken terra cotta ware, and probably completely severed the ulnar nerve just above the styloid process, inasmuch as all forms of sensation, according to the statement of the patient, were entirely lost a few days after the accident in the peripheral distribution of the ulnar nerve. This was the condition noted on his first visit to the hospital. Reaction of degeneration and dryness and brittleness of the nail of the little finger were noted. Suture was advised.

Case III. H. C., aged thirty-six, six days before coming to the hospital awoke after a debauch and noticed that his left eye was blackened, and that he could not feel on the left side of his nose and upper lip. The statement was made that on examination the anesthesia was found to involve the distribution of the left anterior dental nerve. The removal of a piece of bone in a depressed fracture at the left infraorbital foramen was advised, but the patient did not return.

GENERALYZED NEURO-FRIBROMATA.

M. Delore (La Médécine Moderne, April 10th, 1897) reports a case of generalyzed neuro-fibromata in a child eleven years of age.

Three skin tumors appeared successively, one at the age of two years, on the right side of the nose; one at the age of five, on the left tendo-achillis; and the third at eight years of age, a little above the left breast. This was the largest of them all, and extended along the sixth left intercostal space. There was no spontaneous pain, but pressure, or contact with clothing, caused stabbing pains. On palpation there was a sensation as if touching a loose fibrous bundle with numerous nodules distributed upon it.

This neuro-plexiform tumor was removed by M. Vincent. It had two pedicles; one, external, consisting of thickened intercostal nerves; the other, internal, traversed the intercostal muscle, and was formed by an anterior branch of the perforating intercostal nerve. This growth was a fibroma of the nerve-sheath without alterations of the nerve fibres themselves. The other tumors were pure fibromas.